computation.

h. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations above the mean of all Idaho hospitals shall receive a DSH payment equal to six percent (6%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

i. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates exceeding twenty five percent (25%) but less than thirty percent (30%) shall receive a DSH payment equal to four percent (4%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

j. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding thirty percent (30%) shall receive a DSH payment equal to six percent (6%) of the interim payments related to the Medicaid inpatient days included in the MUR computation.

03. Out-of-State Hospitals Eligible for Mandatory DSH Payments. Out-of-state hospitals eligible for Mandatory DSH payments will receive DSH payments equal to one half (½) of the percentages provided for Idaho hospitals in Subsections 02.d through 02.j. Mandatory qualifications in sections 454.02.a, b, c. and e, must also be met.

04. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 454.02, will be designated a Deemed Disproportionate Share Hospital. Out of state hospitals will not be designated as Deemed DSH. The disproportionate share payment to a Deemed DSH hospital shall be the greater of:

a. Five dollars ($5.00) per Medicaid inpatient day included in the hospital's MUR computation; or

b. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the Disproportionate Share Hospital Allotment Amount less the Mandatory DSH payment amount divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals.

c. The Deemed DSH inpatient utilization rate will be each hospital's Idaho Medicaid inpatient days divided by the total

number of patient days reported in the annual DSH survey.

d. Deemed DSH eligibilty and payments are based on an allocation of the remaining DSH allotment after all Mandatory DSH hospital obligations are met. If Mandatory DSH hospitals receive 100 percent of the DSH allotment, Deemed DSH hospitals will not be eligible to receive a DSH payment for that allotment period.

05. Insufficient DSH Allotment Amounts. When the DSH Allotment Amount is insufficient to make the aggregate amount of DSH payments, DSH payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. On a quarterly basis, the state shall monitor DSH payments against the DSH Allotment Amount.

06. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the uncompensated costs incurred during the year of furnishing services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State plan, plus the costs of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.

a. Payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State shall not be considered a source of third party payment.

b. Claims of uncompensated costs that increase the maximum amount which a hospital may receive as a DSH payment must be documented.

455. ORGAN TRANSPLANT AND PROCUREMENT REIMBURSEMENT. Organ transplant and procurement services by facilities approved for kidneys, bone marrow, liver, or heart will be reimbursed the lesser of one hundred percent (100%) of Reasonable Costs under Medicare payment principles or Customary Charges. Follow up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will not be covered.

456. OUT-OF-STATE HOSPITALS.

01. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the State of Idaho will have a cost settlement computed with the State of Idaho if the following

conditions are met:

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or

b. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department.

02. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals.

457. Reserved

458. INSTITUTIONS FOR MENTAL DISEASE (IMD). Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care in a freestanding psychiatric hospital will be covered.

459. AUDIT FUNCTION. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Title XIX purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility.

460. ADEQUACY OF COST INFORMATION. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to recipients. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of Reasonable Costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another.

461. AVAILABILITY OF RECORDS OF HOSPITAL PROVIDERS. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider.

462. INTERIM COST SETTLEMENTS. The Department will initiate interim cost settlements based on the Medicare cost reports as submitted to the Medicare Intermediary.

01. Interim settlement cost report data will be adjusted to reflect Medicaid payment and statistical summary reports sent to providers before the filing deadline.

02. Hospitals which must undergo cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Bureau of Medicaid Policy and Reimbursement, or its designee, upon filing with the Intermediary.

a. The Department may grant extensions for filing the Medicare cost report for circumstances beyond the provider's control.

b. The Department may limit a recovery or payment of an interim settlement amount up to twenty five percent (25%) of the total settlement amount when the cost report information is in dispute.

463. NOTICE OF PROGRAM REIMBURSEMENT. Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment shall be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Title XIX program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the

settlement amount.

01. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary.

02. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement.

464. INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS TO HOSPITALS. The Title XIX program will charge interest on overpayments, and pay interest on underpayments, to hospitals as follows:

01. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement as defined in Section 462., and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense.

02. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges.

03. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly.

04. Retroactive Adjustment. The balance and interest shall be retroactively adjusted to equal the amounts that would have been due based on any changes which occur as a result of the final determination in the administrative appeal and judicial

appeal process. Interest penalties shall only be applied to unpaid amounts and shall be subordinated to final interest determinations made in the judicial review process.

465. RECOVERY METHODS. Recovery shall be effected by one of the following methods:

01. Lump Sum Voluntary Repayment. Pursuant to the provider's receipt of the notice of program reimbursement, the provider refunds the entire overpayment to the Department.

02. Periodic Voluntary Repayment. The provider may make payments or may have recovery made from interim payments based on a request submitted within thirty (30) days of receipt of the notice of program reimbursement.

03. Department Initiated Recovery. The Department shall recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receipt.

04. Recovery from Medicare Payments. The Department may request that Medicare payments be withheld in accordance with 42 CFR Section 405.375.

466. NONAPPEALABLE ITEMS. The formula for the determination of the Hospital Inflation Index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates wich are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed Cost Reports and audits must not be accepted as appealable items.

467. INTERIM REIMBURSEMENT RATES. The interim reimbursement rates are intended to be reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards.

01. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department.

a. For hospitals with more than forty (40) beds, the interim rate will reflect the Title XIX Inpatient Operating Cost

Limits used to set inpatient rates and the Reimbursement Floor Percentage.

b. For hospitals with forty (40) or fewer beds, the interim rates will reflect one hundred percent (100%) of the Medicaid reasonable costs by determining the Medicaid cost-to-charge ratio from the most recent Medicare Cost Report submitted to the Department.

02. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider.

03. Basis for Adjustments. The Department may make an adjustment based on the Medicare Cost Report as submitted and accepted by the Intermediary, after the provider's reporting year, to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement.

04. Unadjusted Rate. The Title XIX interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payers.

468. HOSPITAL SWING-BED REIMBURSEMENT. The Department will reimburse hospitals which meet the requirements found in Idaho Department of Health and Welfare Rules, Title 3, Chapter 9, Section 161, Rules Governing Medical Assistance.

469. (RESERVED).

996. ADMINISTRATIVE PROVISIONS. Contested case appeals shall be governed by Idaho Department of Health and Welfare Rules, Title 5, Chapter 3, Sections 000, et seq., Rules Governing Contested Case Proceedings and Declaratory Rulings.

997. CONFIDENTIALITY OF RECORDS. Information received by the Department in connection with Medicaid provider reimbursement is subject to the provisions of Idaho Department of Health and Welfare Rules, Title 5, Chapter 1, Rules Governing Protection and Disclosure of Department Records (See Appendix 1).

998... (RESERVED)

999. ADMINISTRATIVELY NECESSARY DAY (AND). An Administratively Necessary Day is intended to allow a hospital time for an orderly transfer or discharge of recipient inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for

inpatients who are awaiting placement for NF level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

01. Documentation Provided. The hospital will provide the Department's designee complete and timely documentation prior to the patient's anticipated discharge date in order to be considered. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing, or by telephone. Hospitals must make the documentation and related information requested by the Department's Medicaid Policy Section designee available within ten (10) working days of the date of the designee-'s request in order for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to:

a. A brief summary of the patient's medical condition; and

b. Statements as to why the patient cannot receive the necessary medical services in a nonhospital setting; and

c. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact.

02. Limitation of Administratively Necessary Days. Each recipient is limited to no more than three (3) ANDs per discharge. In the event that a NF level of care is required, an AND may be authorized provided that the hospital documents that no SNF or ICF bed is available within twenty-five (25) miles of the hospital.

03. Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho skilled nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation.

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year.

b. Hospitals with an attached skilled nursing facility

will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and

c. The Department will pay the lesser of the established AND rate or a facility's customary charge to private pay patients for an AND.

04. Reimbursement for Services. Routine services as addressed in Subsection 161.01.a. include all medical care, supplies, and services which are included in the calculation of nursing home property and nonproperty costs as described in Idaho Department of Health and Welfare Rules and Regulations, Title 3, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 126. (12-31-91)

APPENDIX 1 - HOSPITAL APPEALS UNDER CONTESTED CASE RULES

16.05.500. DISPUTED PAYMENTS TO HOSPITALS. If a hospital has a grievance or complaint or requests an exception to the requirements of Idaho Department of Health and Welfare Rules and Regulations Sections 03.10450 -- 03.10499, the hospital can invoke the following procedures:

01. Filing of Dispute. Within thirty (30) days after a provider receives notification of an action or determination, and it has any grievance, complaint, or exception, the provider must identify in writing to the Bureau of Medical Assistance the specific issues involved and specifically describe the disputed action or inaction regarding such issue(s) and the grounds for its contention that an action or determination was erroneous. Any information and copies of any documentation on which the facility intends to rely to support its position shall be included with the initial filing of the dispute.

02. Initial Response to the Dispute. The Bureau of Medical Assistance will acknowledge the written grievance, complaint, or exception and transmit its response to the hospital within thirty (30) days.

03. Intermediate Resolution of the Dispute. If a hospital disputes the conclusions and reasons found in the Bureau of Medical Assistance's response, the hospital can request that the Bureau conduct an informal conference to resolve the issue(s) in dispute.

a. Request. The request for an informal conference must:

i. Be in writing; and

ii. Be specific as to all issues in question: and

iii. Set forth the specific dollar value in question; and